eTiQa Insurance

DISCHARGE MEDICAL REPORT FORM

SECTION I – To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN I – Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)

Name of Insured *Nama Pihak Diinsuranskan*	NRIC No. *No. K/P*	Policy No. *No. Polisi* Plan/Category *Pelan/Kategori*

Claimant (other than the Insured) *Pihak Menuntut (selain daripada Pihak Diinsuranskan)*	Claimant is: *Pihak Menuntut ialah :* ☐ Self/*Diri Sendiri* ☐ Spouse/*Pasangan* ☐ Child/*Anak*	NRIC No. (if applicable) *No. K/P (jika diterima pakai)*

Birth Date *Tarikh Lahir* ☐ (dd) ☐ (mm) ☐ (yy)	Age *Umur*	Sex *Jantina* ☐ Male/*Lelaki* ☐ Female/*Perempuan*	Race *Bangsa*

Religion *Agama*	Marital Status *Status Perkahwinan*	Occupation *Pekerjaan*

Employer *Majikan* Employer's Address *Alamat Majikan*	Tel. No: *No. Tel:* Cheques should be payable to *Cek harus dibayar kepada*
Date of Employment *Tarikh Mula Bekerja*	

Type of Claim / *Jenis Tuntutan*
☐ Hospitalisation/*Dimasukkan ke hospital*
☐ Accident/*Kemalangan*
☐ Outpatient/*Pesakit Luar*

Name of Hospital *Nama Hospital*	Date Admitted *Tarikh Kemasukan*	Date Discharged *Tarikh Keluar*

Name of Illness/Type of Injury *Nama Penyakit/Jenis Kecederaan*	Date First Consulted *Tarikh Pertama Dirawat*

Details of other insurance policies, Socso, Workmen's Compensation and others:-
Butir-Butir polisi insurans lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-

Policy Type/*Jenis Polisi*	Insurance Company/*Syarikat Insurans*	Policy No./*No. Polisi*

AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION
MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.
Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/tanggungan saya termasuk latarbelakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital/menjalani pembedahan kepada syarikat insuran.

.....	.....	.....
Signature of Patient *Tandatangan Pesakit*	Signature of Insured/Claimant *Tandatangan Pihak Diinsurans/Pihak Menuntut*	Date *Tarikh*

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AADBZZ

SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No.:**
SEKSYEN II – Untuk diisi oleh Doktor yang Merawat (DALAM HURUF BESAR) ***No. MRN:***

Name of Hospital and Address
Nama Hospital dan Alamat

Name of Patient
Nama Pesakit

NRIC No.
No. K/P

Date and time of Admission
Tarikh dan Waktu Kemasukan
☐ (dd) *(Tarikh)* ☐ (mm) *(Bulan)* ☐ (yy) *(Tahun)* ☐ (hrs) *(Jam)*

Date and Time of Discharge
Tarikh dan Waktu Keluar
☐ (dd) *(Tarikh)* ☐ (mm) *(Bulan)* ☐ (yy) *(Tahun)* ☐ (hrs) *(Jam)*

Name of Referring Doctor and Address
Nama Doktor Yang Dirujuk dan Alamat

Admitting Doctor
Doktor Kemasukan

Attending Doctors
Doktor Merawat

Speciality
Kepakaran

1a. Diagnosis/ICD Coding
Diagnosa/Kod ICD

1b. Cause and Pathology (if applicable) of the above diagnosis
Punca dan Patologi (jika berkenaan) diagnosa di atas

4a. Please ✓ Nature of Treatment and Investigation:
Tandakan ✓ Jenis Rawatan dan Siasatan:

☐ OPERATION/*PEMBEDAHAN*
☐ PHYSIOTHERAPY/*FISIOTERAPI*
☐ DIETARY COUNSELLING/ *KAUNSELING PEMAKANAN*
☐ MEDICATIONS/*UBAT-UBATAN*
☐ X-RAY/*X-RAY*
☐ BLOOD TESTS/*UJIAN DARAH*
☐ OTHERS,/*LAIN-LAIN*

Give Details/*Berikan Keterangan* .....
.....
.....

4b. If more than one procedure was involved, please state Type of Procedures performed:
Jika melibatkan lebih daripada satu prosedur, sila nyatakan Jenis Prosedur yang dijalankan:

	TYPE *JENIS*	DATE *TARIKH*	NAME OF DOCTOR *NAMA DOKTOR*
i.			
ii.			
iii.			

2a. When did patient first consult you for this condition?
Bilakah pesakit mula merujuk anda mengenai kondisi ini?
☐ (dd) *(hh)* ☐ (mm) *(bb)* ☐ (yy) *(tt)*

2b. Was the patient previously treated for this condition?
Pernahkah pesakit dirawat untuk kondisi tersebut sebelum ini?
☐ No *Tidak* ☐ Yes, give details and when *Ya, beri keterangan dan bila*
☐ (dd) *(hh)* ☐ (mm) *(bb)* ☐ (yy) *(tt)*
.....
.....
.....

2c. How long in your professional opinion has the condition existed?
Berapa lamakah menurut pendapat profesional anda kondisi ini telah wujud?
☐ (dd) *(hh)* ☐ (mm) *(bb)* ☐ (yy) *(tt)*

4c. Other medical conditions present?
Wujud keadaan perubatan yang lain?
.....
Since (dd mm yy) .....
Sejak (hh bb tt)
.....
Since (dd mm yy).....
Sejak (hh bb tt)
.....
Since (dd mm yy).....
Sejak (hh bb tt)
.....

3. Any possibility of a relapse? *Kebarangkalian untuk berulang?*
☐ Yes(*Ya*) ☐ No *(Tidak)*

5. Was the condition/*Keadaan tersebut adalah*
☐ congenital *kongenital* ☐ nervous *cemas* ☐ mental *mental*

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)
Adakah pesakit sedang hamil ketika dimasukkan ke hospital? (Untuk Wanita Sahaja)
☐ No *(Tidak)* ☐ Yes (*Ya*), ... months *(bulan)*

7. If the hospitalisation was due to accident, please indicate date/time of accident.
Jika Kemasukan ke hospital disebabkan oleh kemalangan, sila nyatakan tarikh/masa kemalangan.
☐ (dd) *(hh)* ☐ (mm) *(bb)* ☐ (yy) *(tt)* ☐ (hrs) *(jam)*

8. Discharge/Follow-up instructions
Arahan Keluar/Susulan

.....	.....	.....
Signature and Name of Attending Doctor *Tandatangan dan Nama Doktor Yang Merawat*	Hospital Stamp *Cop Hospital*	Date *Tarikh*